UTAH STATE MEDICAID
NURSING FACILITY
Fiscal Year 2007
QUALITY IMPROVEMENT INCENTIVE APPLICATION

This form and all supporting documentation is due on or before June 8, 2007

Facility Name: _____ I.D. #_____

Administrator: _____

Please mark all that are complete:

- ☐ This facility received no violations that are at the IJ level, as determined by the Department, during the incentive period.
- ☐ This facility received no violations that are a Substandard Quality of Care level F, H, I, J, K, or L, as determined by the Department, during the incentive period.
- ☐ This Facility has a Quality Improvement plan which includes the involvement of residents and family. *(A brief description of our Quality Improvement Plan is attached.)*
    - ☐ This facility has a process by which our Quality Improvement plan is assessed and measured. *(A brief report describing this process and which includes an example demonstrating how the facility assessed, responded to and re-evaluated a clinical quality concern, is attached.)*
    - ☐ This facility has a customer satisfaction survey, conducted quarterly by a recognized and qualified third-party entity. The following information is attached:
        - ☐ Name and brief description of the third-party entity performing the quarterly survey.
        - ☐ Brief description of
            - the survey questions,
            - who is surveyed,
            - when the surveys are done, and
            - how our facility uses the survey results to improve operations/customer satisfaction.
        - ☐ Quarter 1 survey results summary (e.g., a graph, etc.)
        - ☐ Quarter 2 survey results summary (e.g., a graph, etc.)
        - ☐ Quarter 3 survey results summary (e.g., a graph, etc.)
        - ☐ Quarter 4 survey results summary (e.g., a graph, etc.)

Please ensure that the attached documents do not exceed a total of 10 pages.

Administrator Signature:_____ Date:_____